

2014

# Alternative Payment Methodologies:

## A Review of Past, Current, and Future Mechanisms

This report will discuss the current dilemma in the healthcare industry around payment models already in place and examine past and current case studies conducted in the field of payment reform in healthcare in the United States. Models of payment reform will be examined and the steps towards implementing a new payment methodology will be discussed, from logistics to implementation.



## **Executive Summary**

This report provides an analysis and evaluation of the current and prospective models of healthcare payment reform across the United States. Methods of analysis include literature reviews, horizontal analyses, as well as the resulting expenditure savings from adopting particular models. Results of data analyzed show that the models discussed in this report were all successful in varying capacities at decreasing total healthcare cost for both patients and providers. In particular, providers experienced significant savings with particular Shared Savings and Patient-Centered Medical Home models.

The report finds the prospects of the alternative payment methodologies are positive and promising. However, many steps must be taken in order to ensure that payment reform can occur successfully.

Recommendations discussed include:

- Investing in a network of healthcare technology infrastructure to meet quality standards;
- Determining how much financial risk can one afford with payment reform;
- Aligning incentives with proper quality measures; and
- Creating collaborative efforts across the industry.

We conclude that there exist many promising models of alternative payment in order to reform health care, each with varying benefits. While such models and their results are promising, much more work must be done at the community level in order to prepare for payment reform, particularly with the recommendations listed above.

## **Introduction**

An increased expenditure on healthcare has not been correlated with sustained positive health outcomes in the United States. Within the United States itself, different regions and states spend drastically different amounts on health care with no correlation to improved health outcomes. The fee-for-service (FFS) payment system is one of the reasons for the high level of healthcare spending in the United States, and its continued growth over the past 50 years.

In FFS, quantity, not quality, is rewarded. High-cost, high-margin services are rewarded in the healthcare system. Through the FFS system, health care insurers, Medicaid, and Medicare pay doctors, hospitals and other health care providers separately for different items and services administered to a patient. In 2008, 78% of employer-sponsored health insurance was fee-for-service.

There are numerous problems inherent in the FFS system. First, FFS payments drive up healthcare costs and lower the value of care. One reason costs are driven up and value is lowered is because of the emphasis placed on wasteful use, specifically of high-cost items and services. Additionally, there is no process which aligns financial incentives between different providers, and as a result patients receive care that is unneeded and unwanted. Further exacerbating the problem is that all of a patient's healthcare providers may not agree about what care should be administered to him/her. While insurers are generally left to bear the burden of the high costs, the costs are usually passed down to the insured in the form of increased premiums, deductibles, and other cost-sharing methods for all insured individuals, whether they have utilized a large number of services or not.

The most glaring problem with the FFS system is that lack of emphasis placed on encouraging the low-cost, high-value services like preventive care and patient education, despite the potential of improving patient health and lowering healthcare costs system-wide. Due to a lack of preventive care and patient education, patients enter the healthcare system with far advanced versions of chronic and acute diseases that could have been managed properly with less cost had more emphasis been placed on the aforementioned low-cost, high-value services.

Fortunately, with the passage of the Affordable Care Act in 2010, a variety of payment and delivery reforms were included in the legislation, designed to control costs and improve the quality of care, particularly with Medicare beneficiaries. The reforms included in the Affordable Care Act complement the existing innovations

***Alternative Payment Methodologies: A Review of Past, Current, and Future Mechanisms***

occurring in the private sector and simultaneously encourage wider adoption of alternative payment methodologies to FFS in order to increase cost savings and lower overall healthcare expenditure. The alternative payment methodologies will focus on creating incentives to encourage preventive care and an increase coordination of care, particularly for patients with chronic illnesses.

Many alternative payment methodologies are in their nascent stages and are still developing. However, early results suggest that there are many promising alternatives to FFS that can serve as a viable and more efficient alternative to the current system.

There are four models of quality improvement initiatives that will be investigated in this paper: Bundled Payments, Shared Savings, Pay-For-Performance, and Patient Centered Medical Home (PCMH). While each model has significant potential for improving the quality of care, it is important to note that each payer will have varying costs of care, and as a result, each of the aforementioned methodologies will carry a certain level of risk. Two of the main logistical components of payment reform are total cost of care and financial risk, so it is important to definitively define total cost of care for each payer. Furthermore, a shift in payment methodology is a time consuming process that will require patience and an adjustment period. By conducting learning collaboratives and other forums around best practices regarding alternative payment methodologies, this transition period will be easier to navigate.

Oregon's Office of Health Policy and Research released a report documenting alternative payment methodologies. The four most widely discussed alternative payment methodologies are in the table on the next page. Each of the following four alternative payment methodologies will be discussed in detail in this paper.

**Note: The following pages are excerpts from a report released in June 2013 by the Oregon Center for Health Policy and Research, "Healthcare Payment Reform: Alternative Payment Methodologies". The information presented is the property of these two organizations and has been presented here for educational purposes only.**

## **Alternative Payment Methodologies: A Review of Past, Current, and Future Mechanisms**

Providers are typically not compensated appropriately based on care coordination and outcomes. As alternative payment methodologies are implemented, they should support the following objectives:

- Reimburse providers on the basis of health outcomes and quality instead of volume of care;
- Hold organizations and providers accountable for the efficient delivery of care;
- Reward good performance or create shared responsibility across sites of care and provider types;
- Create incentives for the prevention, early identification and early intervention of conditions that lead to chronic illnesses;
- Provide person-centered planning in the design and delivery of care, and use of patient-centered medical primary-care homes; and
- Incentivize coordination across provider types and levels of care.

While there is a high level of consensus among Oregon stakeholders that a revised payment model should promote a value-based, patient-centered health care system, there has not been widespread adoption of such systems. In 2010 however, the Patient Protection and Affordable Care Act (PPACA) mandated several changes in existing compensation programs that have redirected the focus of provider payment system from volume-based to value-based.<sup>1</sup> While payment systems for health care provider reimbursement have primarily utilized fee-for-service and capitation as the dominant payment methods, several alternative payment methodologies exist and some have the potential to control health care costs and increase quality of care. These methods are listed in the following table.

<b>Payment Methodology</b>	<b>Description</b>
<b>Bundled Payment</b>	Providers are paid a set amount for all services rendered during a defined “episode” of care. For example, a pre-determined amount may be paid to multiple providers for a patient undergoing a kidney transplant. This payment would cover the surgery and all services, including follow-up, associated with that “episode”.
<b>Shared Savings</b>	This model evaluates payments made over a period of time and sets cost-saving targets. If providers meet or exceed those targets, they can then share in a portion of the savings. The distribution of savings across multiple providers is typically tied to quality measures and outcomes.
<b>Pay-For-Performance (P4P)</b>	Incentive payments are built on a fee-for service base to reward structure, process, or health outcome achievements. These payments can be calculated as a percentage of the underlying fee-for service payment or a portion of claims paid can be withheld and then redistributed to providers based on quality indicators.
<b>Patient Centered Medical Home Payment (PCMH)</b>	Additional activities and functions related to care management, data/utilization management, and population health are reimbursed by an extra fee that may be capitation or FFS based.

<sup>1</sup> Health Care Incentives Improvement Institute, op. cit.

With the opportunities that the PPACA has presented and early adopters of payment reform initiatives, there are now numerous examples of alternative payment methodologies being implemented at various levels in the health care delivery system. The following is a description of some of these payment reform initiatives that promote the efficient provision of high-quality care.

## **Bundled Payments**

Bundled payments can cover all services rendered during a defined “episode of care”. While not as common as FFS and capitation, bundled payment is not a new concept. For years, Medicare has paid hospitals predetermined amounts based on each patient’s clinical condition categorized as Diagnosis-Related Groups (DRGs). In addition, an early 1990s bundle payment demonstration in Medicare resulted in a 10% expenditure reduction for heart bypass surgeries.<sup>2</sup> Labor and delivery has also historically been paid with a global fee that encompasses several related services. However, the difference is that these bundled payments have typically been paid to a single provider or entity, whereas the new approach is to lump multiple providers and service types together in a bundled payment arrangement that encourages providers to better coordinate care during an episode of care.

In general, bundled payment systems work to combine the services of various partners and build case rates for episodes of care based on historical claims data, allowing for only a portion of the costs associated with potentially avoidable complications. The models can be developed prospectively by providing a predetermined payment up front or retrospectively by developing a budgeted amount for an episode of care and either sharing the savings when there is a surplus, or sharing the losses. A Robert Wood Johnson Foundation (RWJF) study found that potentially avoidable costs constitute roughly 40% of the dollars spent on a set of chronic conditions that included congestive heart failure (CHF), coronary artery disease (CAD), diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and asthma.<sup>3</sup>

Bundled payments should act as an incentive for providers to work together to better coordinate their activities in a value-maximizing way. Despite inpatient care treatments being under the control of the physician, hospitals have been responsible for payments for devices, drugs, and staffing. A bundled payment system would

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<sup>2</sup> Congressional Budget Office. Lessons from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Purchasing. January 2012. Available: <http://www.cbo.gov/publication/42860>.

<sup>3</sup> Francois de Brantes et al. Sustaining the Medical Home: How the Prometheus Payment Can Revitalize Primary Care.

## **Alternative Payment Methodologies:** A Review of Past, Current, and Future Mechanisms

prompt the physician to better coordinate care and manage the utilization of services and resources to contribute to the greater good, thereby receiving a larger payment for their services. In combination with quality metrics and standards, these financial incentives can also promote better quality of care and result in less provider cost-shifting. Better quality of care and care management programs could reduce the need for home care and costly hospital readmissions. The Duke Clinical Research Institute estimated that proposed bundled payments for all heart failure care within 30 days of hospitalization, along with tested disease management programs to reduce readmissions, could lead to savings of \$347 per patient.<sup>4</sup>

Factors thwarting the implementation of bundled payment systems have been identified as fragmented provider networks, clearly defining episodes of care, administrative burdens associated with bundle packaging and payment distribution, and concerns about complications of chronic disease not being reflected in compensation. However, new provisions set forth within the ACA supporting payment reform and technological advantages such as health information technology that can also work to advance care coordination have sparked payers' interest in their ability to use the bundled payment model. Several promising bundled payment initiatives are described below.

### **Geisinger's ProvenCare**

ProvenCare is a Geisinger Health System (GHS), initiative that began with episode of care payments for coronary artery bypass graft (CABG) surgery. This approach requires that for each case, surgeons explicitly ensure that surgery is appropriate, document a shared decision-making process with the patient, and initiate post discharge follow-up to ensure compliance with medication and rehabilitation recommendations.<sup>5</sup> To ensure evidence-based care, there are 40 benchmark steps involved in CABG surgery under ProvenCare.<sup>6</sup> The key aspect of ProvenCare is a flat payment for surgery and all related care for 90 days after discharge. The flat rate assumes that GHS will reduce its historical complication rate by half. An evaluation of the first year's experience with Geisinger's ProvenCare coronary bypass bundled payment program showed a 10% reduction in readmissions, shorter average length of stay, reduced hospital charges, and a 44% decrease in hospital

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<sup>4</sup> Zubin J. Eapen, M.D., Shelby D. Reed, Ph.D., Lesley H. Curtis, Ph.D., et al. Do heart failure disease management programs make financial sense under a bundled payment system. *American Heart Journal* 161(5), pp. 916-922.

<sup>5</sup> Lee TH. "Pay for Performance, Version 2.0?" *New England Journal of Medicine* 357, no.6 (2007): 531-533.

<sup>6</sup> Information provided on Geisinger Health System's website at:  
<http://www.geisinger.org/provencare/benchmarks.html>.

admissions over an 18 month period.<sup>7</sup> In the five-plus years since they first convinced their cardiac surgeons to adapt to standardized care, and aside from improving their methods for CABGs, Geisinger has expanded to bundled payment for elective coronary angioplasty (PCI), total hip replacement, bariatric surgery for obesity, perinatal care, and treatment for chronic conditions. The success of this program is also attributed to Geisinger's unique structure as a physician-driven, integrated delivery network with a system-wide electronic health record (EHR) and dominant market share.

### **Prometheus Payment Model**

Developed in 2006, the Prometheus Payment Model packages payments around comprehensive episodes of medical care that cover all patient services related to a single illness or condition rather than paying for discrete visits, discharges, or procedures. To date, the Prometheus Payment model has developed numerous Evidence-Based Case Rates (ECRs) for these episodes that include hip and knee replacements, diabetes, asthma, congestive heart failure, and hypertension. These existing ECRs can potentially impact payment for almost 30% of the entire insured adult population and represent a significant amount of dollars spent by employers and plans.<sup>8</sup> This model encourages two behaviors that FFS discourages: 1) collaboration of physicians, hospitals, and other providers involved in a patient's care; and 2) active efforts to reduce avoidable complications of care (and the costs associated with them).<sup>9</sup> It essentially works to eliminate cost related to potentially avoidable complications (PAC) under the provider's control such as hospitalizations resulting from an uncontrolled chronic condition or inappropriate wound care after a surgical procedure. For hip and knee replacements alone, one study found that 14% of total costs could be avoided in relation to PACs.<sup>10</sup> Essentially, the Prometheus model creates a global price for a procedure, or an ECR, that differentiates between typical care and PACs and is adjusted based on the severity of the patient's injury or illness.

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<sup>7</sup> Mechanic RE and Stuart HA. Payment Reform Options: Episode Payment is a Good Place to Start. *Health Affairs*, 28, no. 2 (2009): w262-w271. (published online January 27, 2009; 10.1377/hlthaff.28.2.w262).

<sup>8</sup> Prometheus Payment, Inc. What is Prometheus Payment? An Evidence-Informed Model for Payment Reform. 2009. Available: <http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/06/what-is-prometheus-payment.html>.

<sup>9</sup> De Brantes F, Rosenthal MB, Painter M. Building a bridge from fragmentation to accountability-the Prometheus Payment Model. *New England Journal of Medicine* 2009;361(11): 1033-1036.

<sup>10</sup> Rastogi A, et al. Prometheus Payment Model: Application to Hip and Knee Surgery. *Clinical Orthopedics and Related Research* 2009, Oct: 467(10):2587-2597.



## **Alternative Payment Methodologies:** A Review of Past, Current, and Future Mechanisms

Since the Model was developed, several pilots supported by the RWJF have commenced. Three initial pilots resulted in lessons learned that have been formulated into an implementation toolkit developed by the Health Care Incentives Improvement Institute (HCI3) at <http://www.hci3.org/?q=node/101>. Dozens of payers and other agencies have used the tools created by the Institute to estimate the costs of their episodes of care. In June 2012, there were at least 19 pilots in the United States implementing bundled payment programs with public and private sector payers, and nearly half were using the PROMETHEUS Payment model. Of note, Maine's State Innovation Model identified that they will be using the PROMETHEUS model to evaluate episodes of care using their All Payer Claims Database (APCD) for the Medicare, Medicaid and the commercial population.

### **California Public Employees' Retirement System<sup>11,12</sup>**

In 2008, elective hip and knee replacements cost the California Public Employees' Retirement System (CalPERS) \$55 million. Because the hospital bills ranged from \$15,000 to \$110,000 with no discernible difference in quality, CalPERS limited what it would be for knee and hip replacement surgeries to \$30,000. It found multiple high quality hospitals willing to stay within that threshold amount, and its average price per surgery dropped almost 28% to \$23,113 in 2011. Members of some of the CalPERS plans have 100% coverage, including the cost of travel, when electing to receive these procedures at a participating hospital or facility. In 2012, CalPERS applied thresholds to PPO outpatient hospital utilization for colonoscopies (\$1,500), cataract surgeries (\$2,000), and arthroscopies (\$6,000). Members are required to pay any charges above the threshold when using outpatient hospitals instead of ambulatory surgical centers.

### **Arkansas Payment Initiative**

Public and private health care payers in Arkansas are undertaking a multi-payer bundled payment initiative led by the Arkansas Department of Human Services to align financial incentives with quality outcomes. The initiative has identified several episodes of care that include hip/knee replacements, acute/post-acute chronic heart failure, ADHD, perinatal and more in which they make retrospective payments to a principal accountable provider (PAP). To identify a PAP, payers use claims data for each episode of care to determine which physician practice, hospital,

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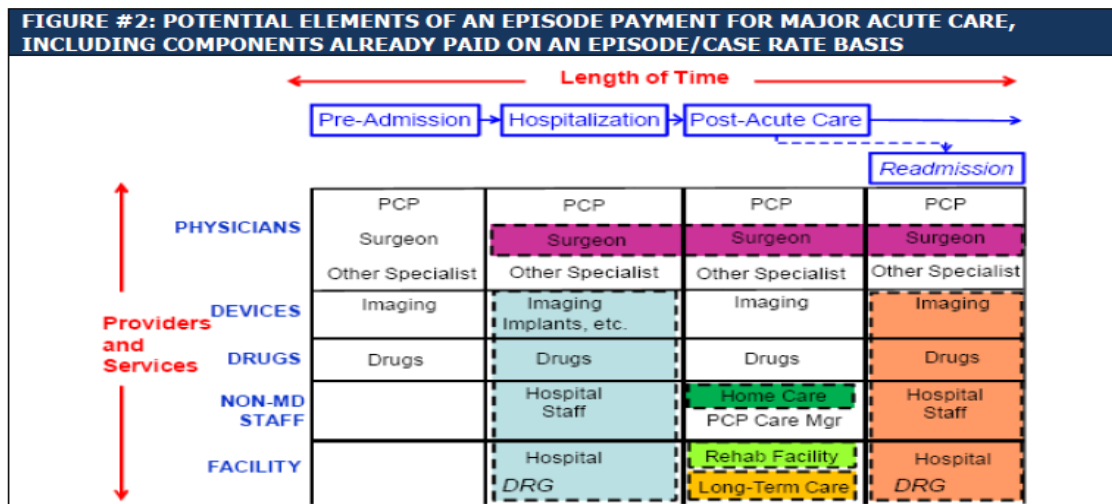
<sup>11</sup> Robinson JC, MacPherson K. Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers. *Health Affairs* 31, No. 9 (2012): 2028-2036.

<sup>12</sup> Donnenson K. California Public Employees Retirement System (CalPERS). Bundled Payments: What's Happening? Presentation at the Healthcare Financial Management Association Southern California and San Diego/Imperial Chapter Fall Conference: September 9, 2012.

**Alternative Payment Methodologies:** A Review of Past, Current, and Future Mechanisms

or other provider is most responsible and accountable for the quality and cost of care. If the PAP meets quality standards and has average costs below a specified threshold they will share in savings up to a 50% limit. Conversely, costs above a specified threshold will also be shared with the PAP at 50%. Savings from this initiative are expected to come across inpatient hospital, outpatient hospital, professional specialty care, diagnostic imaging/ x-ray, laboratory services, DME, dialysis procedures, other professional (e.g., PT, OT, etc.), and prescription drugs categories. Reductions in volume for hospitals will be offset by gain sharing for more efficient hospitals and for some episodes, effective reimbursement will increase for high-quality, efficient physicians and other professional designated PAPs. For more information, see [www.paymentinitiative.org](http://www.paymentinitiative.org).

While bundled payments show promising results, defining and coordinating episodes of care can be complicated. It is thought that payers should start with episodes of care with the highest volume and cost that have actionable standards of care. As identified in the examples above, bundled payments have generally involved episodes such as CAGBs and angioplasty, hip and knee replacements, chronic heart failure, and perinatal. Once an episode of care is selected, payers must work with provider groups and hospitals and assess the data to determine what services and supplies are necessary to provide quality and value-based care. In addition, it must also be established what types of post operative acute care would be included in the bundle for each episode and how much will be allowed for potentially avoidable complications. The figure below provides a helpful visual of the potential elements involved in bundled payments for episodes of care.



Source: The Center for Healthcare Quality and Payment Reform. Paths to Healthcare Payment Reform: Transitioning to Episode-Based Payment Available at: [www.chqpr.org](http://www.chqpr.org).

## ***Alternative Payment Methodologies:*** A Review of Past, Current, and Future Mechanisms

There are also a few barriers to consider. For instance, bundled payment systems do not prevent episodes from happening. While this payment methodology focuses on the course of treatment during an episode, there is no attention paid to preventing the episodes other than readmissions for preventable complications. Secondly, a majority of payers need to participate in bundled payment initiatives to change practice behavior. If only a subset of payers move away from FFS payment, providers that change care in a way that will be supported under improved payment systems will be penalized financially for those patients still being paid for under FFS. On the other hand, providers will fail financially for patients covered by the newer payment systems if they continue to deliver care consistent with traditional FFS incentives.<sup>13</sup>

Lastly, hospitals play a large role in episode of care coordination and payment. However, their willingness to participate in such payment models that work to reduce hospital admission has been tempered by their need for sustainability. Hospitals, while representing the largest share of total health care costs, are generally disadvantaged in payment reform efforts due to their need to support fixed costs. As a practical matter, if health care spending is to be reduced, some or even all hospitals in each region will have to experience a decrease in volume, and this can have a negative impact on those hospitals' operating margins, because with fewer admissions, a hospital's costs will decrease far less than will its revenues, particularly in the short run.<sup>14</sup> To foster hospital participation, efforts and agreements must address their unique needs and challenges. For example, payers may need to increase payment amounts for a transition period to reflect the fact that a hospital's unit costs will be higher with lower volumes, but hospitals must also aggressively look for ways to reduce their fixed costs and be more transparent about their cost structures.<sup>15</sup> Hospitals may also need to find ways to increase their market share without the traditional means of competition amongst hospitals (e.g., purchasing the latest technology and remodeling facilities).

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<sup>13</sup> Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Center for Healthcare Quality and Payment Reform. December 2012.

<sup>14</sup> Miller HD. Methodology on adverse events. Health Affairs (Millwood). January/February 2007. 26(1):293.

<sup>15</sup> Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Op.cit.

## **The Potential of Bundled Payments**

Bundled payments offer benefits for payers, providers, and patients. Using bundles has the following benefits:

1. More coordinated patient care for improved health outcomes and lower costs;
  - a. A reduction in variation in clinical treatment pathways ensure that all patients receive evidence-based best care practices, avoid preventable hospital readmissions, and streamline services across all providers in order to eliminate waste and determine the most efficient mix of services for the patient.
2. Reduced variation in spending and clinical treatments to reduce costs;
3. Greater transparency and accountability on price and quality; and
4. Allow providers to transition to wider-scale payment reforms.

## **Shared Savings**

There are opportunities for shared savings when members are healthy and not in need of high-cost care such as emergency room visits. As with bundled payments, shared savings has been gaining interest as an approach to healthcare payment reform. As mentioned above, this model typically evaluates payments made over a period of time and sets cost-saving targets for the ensuing period (most often a year). If providers meet or exceed those targets, they can then share in a portion of the savings referred to as “upside risk”. However, “downside risk” may be spread across the providers when targets are not achieved. The desired outcome is that the payer spends less on unnecessary services and tests and the provider gets more for providing quality care. Several successful shared savings initiatives exist today and have shown positive results.

### **Medicare Shared Savings Program (ACOs)**

The Medicare Shared Savings Program (MSSP) establishes rewards for participants who lower their growth in health care costs while meeting a detailed quality performance standard. Hospitals, providers, and suppliers providing care to Medicare Fee-For-Service (FFS) beneficiaries may participate in the MSSP by forming an Accountable Care Organization (ACO). The goals of the MSSP are to improve beneficiary outcomes and increase care value through promoting accountability via 33 quality measures for Medicare FFS beneficiary care, requiring coordinated care for all Medicare FFS services, and encouraging redesigned care processes and investment in infrastructure.<sup>16</sup> Early participants in the MSSP are finding success and savings. A Commonwealth Fund report covering early adopters of the ACO model details NewHealth Collaborative (Summa Health system) lowering its 2011 Medicare Advantage costs by 8.4% largely through reduced hospital use including a 10% reduction in readmissions.<sup>17</sup> In addition to cost savings, NewHealth also reports increased physician engagement resulting from financial incentives, education, support, and an understanding of the value of infrastructure investments including electronic health records.

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<sup>16</sup> The CMS Medicare Shared Savings Program (SSP) website available at:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/index.html>.

<sup>17</sup> Silow-Carroll S, Edward JN (Health Management Associates). Early Adopters of the Accountable Care Model: A Field Report on Improvements in Health Care Delivery. The Commonwealth Fund. March 2013.

## **Blue Cross Blue Shield of Massachusetts Alternative Quality Contract**

In 2009, Blue Cross Blue Shield of Massachusetts (BCBS) implemented a global payment system called the Alternative Quality Contract (AQC). Hospitals and physicians make up providers groups in the AQC system and take responsibility for the full continuum of care received by their patients-including the cost and quality of that care-regardless of where the care is provided. The participants bear financial risk (downside risk) share in savings (upside risk). These provider groups are also eligible to receive bonuses for quality. The AQC employs a population-based global budget coupled with significant financial incentives based upon performance on a broad set of quality measures. An analysis of the first year showed that the AQC was associated with significant quality improvement and 1.9% slower growth in medical spending in 2009 relative to the rest of the network not under an AQC. This figure includes incentives payments of approximately 3% on average. An analysis of the second year (2010) found a 3.3% slower growth in spending. BCBS of Massachusetts reports that savings were more dramatic among AQC groups that had been paid on a fee-for-service basis before the contract. AQC provider groups in this category achieved a first-year savings of 6.3% and second-year savings of almost 10%. For 2009 and 2010, the AQC groups were able to reduce spending largely by referring patients to lower-cost facilities for services, such as imaging and lab testing, and by reducing these areas of utilization.

## **Texas Medicaid Gain Sharing Program and Quality Challenge Award<sup>18</sup>**

Medicaid managed care contracts in Texas require MCOs to conduct pilot “gain sharing” programs that focus on collaborating with network physicians and hospitals in order to allow them to share a portion of the MCOs savings resulting from reducing inappropriate utilization of services, including inappropriate admissions and readmissions related to Potentially Preventable Events (PPE). These programs must include mechanisms for incentive payments to hospitals and physicians for quality care and include quality metrics required for incentives, recruitment strategies of providers, and a proposed structure for payment.

Texas Medicaid contracts also include a Quality Challenge Award whereby 5% of a MCO’s capitation can be withheld based on performance-based measures. Should an MCO not achieve those performance levels, future monthly capitation payments will be adjusted by an appropriate portion of the 5% at-risk amount. Unearned funds from the performance-based at-risk portion of an MCO’s capitation rate are

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<sup>18</sup> Texas Health and Human Services Commission. Texas Medicaid Managed Care Quality Strategy: 2012-2016. Available at: [www.hhsc.state.tx.us/1115-Quality-Strategy.shtml](http://www.hhsc.state.tx.us/1115-Quality-Strategy.shtml).

## ***Alternative Payment Methodologies:*** A Review of Past, Current, and Future Mechanisms

redirected to the MCIO Program's Quality Challenge Award (QCA) to annually reward MCOs that demonstrate superior clinical quality, service delivery, access to care, and/or member satisfaction. In the first year, readmissions-related savings could reach \$120 million and the state expected even more savings for complications adjustments. The state found that mental health conditions were the most frequent reason for preventable readmissions.<sup>19</sup>

### **Conclusions**

Despite positive results from shared savings programs across the country, there are some concerns about negative impacts of this approach. Literature from the Center for Healthcare Quality and Payment Reform claims that the shared savings model as it is today is not sustainable because it does not change the underlying payment system, it can reward high spenders rather than high performers, and it can also result in a reduction in revenues for some providers and hospitals. However, the Center explains that shared savings could be done in a few ways: 1) with payers and providers sharing risk for value-improvement programs with a high return on investment and 2) by recalibrating hospital payment levels to allow for enhanced rates reflecting revised costs in order to discourage hospitals from raising rates to compensate for lost revenue from reduced admissions.<sup>20</sup>

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<sup>19</sup> National Association of Medical Directors. Spotlight on States: Texas' Payment Adjustment Policies. July 23, 2012. Available at <http://medicaiddirectors.org/node/481>.

<sup>20</sup> The Center for Healthcare Quality and Payment Reform. Paths to Healthcare Payment Reform: Is "Shared Savings" the Way to Reform Payment? Available at: <http://www.chqpr.org/downloads/SharedSavings.pdf>.

## **Pay For Performance**

Pay-for-performance (P4P) is a method of reimbursing providers based on the achievement of pre-determined measures of quality. Quality can be outcome-based and measured in terms of benchmarking, or quality can be process-based and measured in terms of improvement.<sup>21</sup> There is a growing interest in these programs due to variation in quality across providers, difficulty within the current payment system to reward high-quality, cost-effective care, and the lack of incentive within the current system to encourage providing services with long-term health or cost savings payoffs.<sup>22</sup> Proponents of P4P also argue that consumer choice alone does not provide sufficient incentive for providers to improve their quality of care and that consumers do not consistently use available information on quality to aid in their healthcare decision-making.<sup>23</sup>

The most common form of P4P financial incentive is the bonus payment. Bonus payments are monetary sums paid to providers in addition to the usual fee associated with a service if the provider reaches certain quality goals. There are various types of bonus payments as well as a few additional methods of financial incentives used in P4P systems, identified in the table below.

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<sup>21</sup> Llanos K, Rothstein J, Dyer MB, et. Al. Pay-for-Performance in Medicaid: A Guide for States. Center for Healthcare Strategies, Inc. March 2007.

<sup>22</sup> Nichols LM, O'Malley AS. Hospital Payment Systems: Will Payers Like the Future Better Than the Past? Health Affairs. 2006; 25(1): 81-93.

<sup>23</sup> Rosenthal MB, Fernandopulle R, Song HR, et. Al. Paying for Quality: Providers' Incentives for Quality Improvement. Health Affairs. 2004; 23(2): 127-141.



**Alternative Payment Methodologies: A Review of Past, Current, and Future Mechanisms**

TYPE OF P4P	DESCRIPTION
<b>Bonus or Withhold</b>	Reward payments can be made through a bonus pool, disbursed at the end of the measurement period. Some payers use withholds and might withhold 5% or 10% of physicians' fees. Employers might withhold a small percentage of premiums paid to health plans.
<b>Penalties</b>	Payers may reduce payments to provider organizations and physicians who do not achieve an acceptable level or improvement of performance.
<b>Fee Schedule Adjustment</b>	Payers may adjust fee schedule payments up or down, depending on performance, by adjusting the conversion factor that translates fee schedule relative value units (RVUs) per service into dollar payments.
<b>Per-Member Payment</b>	In capitated environments, or plans in which patients are enrolled with primary care providers, a health plan might pay providers an additional or incremental per member per month or per member per year payment that is contingent on measured performance.
<b>Differential Payment Update</b>	Payers can reward provider organizations and physicians that perform well with an update factor to their payments that is higher than those given to provider organizations and physicians that perform poorly.
<b>Payment for Provision of a Service</b>	A payer can establish payment, or enhanced payment, for service that further the goals of the P4P program.
<b>Payment for Participating/Reporting</b>	Programs might pay provider organizations and physicians to engage in performance-enhancing activities, such as developing quality improvement action plans, attending continuing education programs, or implementing computerized physician order entry. Alternately, payers might pay provider organizations and physicians for reporting performance measures.
<b>Lack of Payment for Poor Performance</b>	Payers can deny payment for services that appear to be ineffective, harmful, or inefficient.
<b>Shared Savings</b>	Payers can give providers incentives to improve efficiency and generate savings by allowing them to share in the realized savings.
<b>Quality Grants or Loans</b>	A provider could apply to a payer for a grant to implement quality-enhancing infrastructure changes, such as an EMR or patient registry.

**Source:** Cromwell J, Trisolini MG, Pope GC, et al. Pay for Performance in Health Care: Methods and Approaches, pp. 50-52. Research Triangle Institute, March 2011.

## **Medicare Physician Group Practice Demonstration<sup>24</sup>**

In April 2005, CMS launched its first value-based purchasing pilot or “demonstration” project- the Medicare Physician Group Practice (PGP) Demonstration. In the Medicare PGP demonstration, the CMS contracted with 10 large multispecialty groups with diverse organizational structures, including free-standing physician groups, academic faculty practices, integrated delivery systems, and a network of small physician practices. National benchmarks and group specific quality improvement targets were used to provide incentives for quality improvement as well as to recognize groups that are achieving high levels of performance. The PGPs earned performance payments of up to 80% of the savings they generated, while the Medicare Trust Funds retained at least 20% of the savings. In year five, quality scores increased from the baseline to an average of 11% on diabetes measures, 12% on heart failure measures, 6% on coronary artery disease measures, 9% on cancer screening measures, and 4% on hypertension measures. In year five alone, the groups received performance payments totaling \$29.4 million as their share of the \$36.2 million of savings generated for the Medicare Trust Funds in that year. This program has been said to be the model for health reform’s ACO provisions.<sup>25</sup>

## **Bridges to Excellence**

Bridges to Excellence (BTE) is a not-for-profit multi-stakeholder organization that has been working with physicians, hospitals, employers, and health plans on implementing incentives and rewards programs for more than five years in different geographic sites across the United States. In order to receive BTE recognition, eligible clinicians must pass a corresponding performance assessment program administered by one of the BTE-recognized Performance Assessment Organizations that includes the National Committee for Quality Assurance (NCQA). BTE measures quality of care in physician practices with programs that include all chronic conditions, physician office systems, and even medical home practices.<sup>26</sup> One report suggests that physicians participating in BTE programs provided higher

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<sup>24</sup> Centers for Medicare and Medicaid Services. Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration (PGP Demonstration Fact Sheet). July 2011. Available at: <http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations.html>.

<sup>25</sup> Iglehart JK. Assessing an ACO Prototype-Medicare’s Physician Group Practice Demonstration. *New England Journal of Medicine*. January 2011; 364:198-200.

<sup>26</sup> Bridges to Excellence: A Vision to Transform U.S. Healthcare: The Programs that Make it a Reality. Health Care Improvement Incentives Institute Vision Brochure. 2009. Available at [http://www.hci3.org/what\\_is\\_bte/tools\\_and\\_resources](http://www.hci3.org/what_is_bte/tools_and_resources).

## **Alternative Payment Methodologies:** A Review of Past, Current, and Future Mechanisms

quality care at lower cost than nonparticipating physicians.<sup>27</sup> The report found that the incremental benefit when a physician earns BTE recognition can be estimated to be roughly \$250 per patient for the health plan. BTE's analyses of claims data comparing patients that are seen by BTE-recognized physicians and those that go to non-recognized physicians shows conclusively that their average severity-adjusted cost of care is lower by about 10%.<sup>28</sup>

In 2006, a number of Colorado health plans and employers joined together to implement the Bridges to Excellence (BTE) diabetes and cardiac programs. Under the leadership of the Colorado Business Group on Health (CBGH), these groups agreed to recognize and reward physicians who voluntarily applied to this national organization and who could demonstrate that most of their patients could meet rigorous standards for metrics on blood pressure, cholesterol, blood sugar, and other vital statistics. By December 2011, 670 recognitions to 334 physicians had been awarded. Since 2006, CBGH has observed that for diabetes, BTE recognized physicians have lower cost and lower utilization in terms of a lower number of emergency room visits (7%), less total days spent in a hospital (18%), and a lower frequency of hospital admissions (15%).<sup>29</sup>

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<sup>27</sup> Rosenthal MB, de Brantes FS, Sinaiko AD, et al. Bridges to Excellence-Recognizing High-Quality Care: Analysis of Physician Quality and Resource Use. *American Journal of Management and Care*. 2008; 14(10):670-677.

<sup>28</sup> Health Care Incentives Improvement Institute. Frequently Asked Questions. Available at: <http://www.hci3.org/content/frequently-asked-questions-faqs-media>.

<sup>29</sup> Colorado Business Group on Health. Colorado Health Matter 2011-2012: Quality Report: Physicians, 2012. Available at: [www.ColoradoHealthOnline.org](http://www.ColoradoHealthOnline.org).

## **Patient Centered Medical Home Payment Models**

The patient centered medical home (PCMH) is a care delivery model that facilitates coordination of patient treatment through their primary care physician. Care received through a medical home is patient centered, comprehensive in addressing all the needs of the patient, coordinated across the health system, and easier to access. Providing such care requires a team-based approach to care that involves physicians, nurses and medical assistants as well as pharmacists, nutritionists, social workers and care coordinators. The PCMH model also integrates behavioral and mental health and specialty services to provide better coordinated care for the patient.

Currently, these facilities provide essential primary care functions such as care coordination that are largely unpaid. The fee-for-service payment model fails to recognize the complexity and intensity of primary care, devalues the work of all members of the primary care team, contributes to overwork and burnout of clinicians, does not assess and reward quality care, and decreases opportunities for meaningful communication between patients and their health care teams. However, there are alternative payment models that support PCMHs by decreasing their cost of care, incenting and rewarding quality over quantity, and enabling practices to invest in infrastructure and supports (e.g., extended office hours and increased communication between providers and patients via email and telephone). Some states certify a site as a patient centered medical home, such as Oregon's Patient-Centered Primary Care Home program, while others seek certification through the National Committee for Quality Assurance or through individual health plans in order to participate in alternative payments. The Patient-Centered Primary Care Collaborative is broad-based national advocacy organization for the primary care PCMH, providing information and networking opportunities to facilitate support for the PCMH. Many states and health plans have used the work developed by the PCPCC have developed model language for inclusion in health reform proposals to include the PCMH concept.

There are four types of Medical Home Alternative Payment Models that exist today:

## Alternative Payment Methodologies: A Review of Past, Current, and Future Mechanisms

PAYMENT MODEL	DESCRIPTION	DETAILS
<b>Enhanced FFS evaluation and management payments</b>	Based on current FFS model but would pay providers more for visits to help pay for medical home activities like care coordination and prevention activities	<ul style="list-style-type: none"> <li>Assumption is that providers would feel less pressure to generate more visits, spend more time with patients at each visit, and support other medical home activities that are unsubsidized</li> <li>Providers might try to generate more office visits or not invest in desired activities</li> <li>Payers may add a mechanism to ensure that the enhanced payments are being used to support medical home activities</li> <li>Enhanced payment should also reflect complexity of patient population</li> <li>Administratively straight-forward</li> </ul>
<b>Additional codes for medical home activities within FFS payments</b>	Based on FFS model but adds CPT codes for services not currently paid for such as transitions in care, expanded hours of services and care coordination	<ul style="list-style-type: none"> <li>Administratively straight-forward</li> <li>Desired medical home activities (enhanced communication and access) may be hard to identify for providing additional fees</li> <li>Easier to provide payments for palliative care conferences for families/patients or activities to improve transition from hospital to community at discharge</li> </ul>
<b>PMPM medical home payments to supplement evaluation and management FFS payments</b>	Adds a capitation element (PMPM) into the FFS model	<ul style="list-style-type: none"> <li>Most commonly recommended by the four national physician specialty societies promoting PCPCHs as well as the Patient Centered Primary Care Collaborative (PCPCC)</li> <li>FFS reimbursement continues at established rates. PMPM payment given to medical home that demonstrate PCPCH components</li> <li>Would need to certify which practices are eligible for PMPM payments and also for which patients extra payments should be made</li> <li>Sometimes a performance based payment is included based on quality, utilization, or patient satisfaction measures</li> </ul>
<b>Risk-adjusted, comprehensive PMPM payment</b>	A type of capitation but sets up a single payment to cover all primary care services not just medical home activities	<ul style="list-style-type: none"> <li>To avoid pitfalls associated with capitation, this approach could combine robust risk adjustment, substantial supplemental PMPM payments to support multi-disciplinary team-based medical home activities and P4P</li> <li>Provides practice flexibility to invest in personnel and technology for primary care</li> <li>Easy for payers to implement</li> </ul>

**Source:** Merrell K, Berenson RA. Structuring Payment for Medical Homes. *Health Affairs*, 29, no. 5 (2010): 852-858.

## **Alternative Payment Methodologies: A Review of Past, Current, and Future Mechanisms**

Almost all current and past medical home programs use a payment approach that is a combination of care coordination payments (usually PMPM) and performance based payments on top of existing FFS payments (the third payment model above). Performance based payment include paying practices for performance on different combination of quality, utilization, or patient satisfaction measures. Additional examples of medical home payment approaches are listed below.

### **Horizon Healthcare Services Inc. (New Jersey)<sup>30</sup>**

There is an ongoing collaboration between Horizon, a large insurance company and primary care providers and physician associations to develop a medical home program and transform practices into NCQA-recognized medical homes. The pilot program included 8 practices and looked at all Horizon members (24,000 members) served by those practices. Horizon paid practices a care coordination fee (\$2.00-\$3.50 PMPM) to support practice transformation and for the provision of additional services under the model. This payment was in addition to the existing fee-for-service reimbursement. Practices were also eligible for additional payments based on meeting quality and utilization-based outcomes. In addition to payments, practices received data and reports at the patient level that identified patients who might benefit from outreach. Horizon also hired population care coordinators to help practices with outreach and other work that were embedded within the practices. Early data results show improved performance on quality measures (increase in screenings, better diabetes control) and utilization measures (lower cost of care, lower rate of ER visits, hospital readmissions, patient admissions, higher use rate of use of generic prescriptions).

Currently, an expanded version of this program is being implemented that includes 48 practices serving 154,000 Horizon members. In this expanded model, practices receive a care coordination fee of \$3.00-\$5.00 PMPM. Practices are eligible for additional payments based on quality, utilization and patient experience measures at two levels. At the basic level, practices can receive between \$0.50-\$9.00 PMPM by showing improvement on quality, utilization and patient experience measures. At the advanced level, practices can directly participate in a shared savings model and receive a portion of the savings that Horizon achieves. In addition to these payments, practices receive a \$2.00-\$5.00 PMPM payment to fund the care coordinator position. Results from the expanded version of the model are not yet available.

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<sup>30</sup> Urvashi B. Patel, Carl Rathjen and Elizabeth Rubin. Horizon's Patient-Centered Medical Home Program Shows Practices Need Much More Than Payment Changes to Transform. *Health Affairs*, 31, no. 9 (2012). 2018-2027.

## **Wellpoint Medical Home Pilots (Colorado and New Hampshire)<sup>31</sup>**

Wellpoint participated in early collaborations between health plans and practices to transform primary care. In Colorado, as part of a much larger program called the Colorado Multipayer Patient-Centered Medical Home program, a pilot program targeted 6,200 Wellpoint patients. Wellpoint paid practices a care coordination fee and payment based on quality and utilization measures on top of the existing fee for service payments. The amount of the care coordination fee depended on the level of recognition the practices received through NCQA. Practices achieving the highest level of recognition could receive \$7.50 PMPM while practices with level 2 recognition received \$6.00 PMPM. In Colorado, patients in the pilot practices showed an 18% decrease in the rate of acute inpatient admissions over the study period compared to the control population as well as a 15% decrease in total ER visits and improvements across all measures of diabetes control.

A similar pilot in New Hampshire also provided a care coordination fee and performance based fee on top of existing fee for service payments and covered 10,000 Wellpoint patients. The care coordination fee was also based on the level of recognition the practice received through NCQA, \$2 PMPM for level 1, \$4 for level 2. Overall PMPM costs declined from the pre to the post study period while costs increased in the control group. The pilot population had a greater decline in ER visit rate.

## **HealthPartners Health Plan<sup>32</sup>**

HealthPartners Health Plan in Minnesota conducted a study of health plan enrollees that looked at the differences between enrollees using a patient-centered medical home (PCMH) clinic compared to those enrollees that do not. Findings revealed that enrollees using a single PCMH had fewer primary and specialty care visits and total lower primary costs compared to those who did not receive care at a single PCMH. Enrollees using a PCMH had an average of 4.53 total visits (primary + specialty care) compared to those without a PCMH that had an average of 6.04 total visits during the same time period. Enrollees using a PCMH had total average costs (primary + specialty care) of \$838.40 compared to average costs of \$1079.90 for those enrollees without a PCMH during the same period. Associated with the Health Plan, HealthPartners Medical Group in Minnesota implemented a PCMH

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<sup>31</sup> Raskas R, et al. Early Results Show Wellpoint's Patient-Centered Medical Home Pilots Have Met Some Goals for Costs, Utilization, and Quality. *Health Affairs*, 31, no. 9 (2012): 2002-2009.

<sup>32</sup> Fontaine P, et al. Is Consistent Primary Care Within a Patient-Centered Medical Home Related to Utilization Patterns and Costs? *Journal of Ambulatory Care Management*. January/March 2011: 34(1), 10-11.

model at its practices. The model included better care coordination and access to primary care. An evaluation study found a 39% decrease in emergency visits and 24% decrease in admissions after implementation of the PCMH model.

### **Community Care of North Carolina**

Community Care of North Carolina (CCNC) is a partnership between North Carolina Medicaid, a large funder of healthcare, primary care physicians, and other health care providers to achieve better outcomes for the management of care for Medicaid recipients in the state. The CCNC program has approximately 1,200 primary care practices (about 50% of all such practices in the state) that manage the care of 750,000 Medicaid patients across the state (about 10% of the total state population). All patients in the CCNC are linked to a medical home. Practices in the CCNC engage in quality improvement efforts, case manage high-risk patients and use quality data to plan interventions. Analyses looking at CCNC show savings in emergency department utilization (23% less than projected), outpatient care (25% less than projected) and pharmacy (11% less than projected).<sup>33</sup>

### **Medicare Advanced Primary Care Practice (MAPCP) Demonstration**

Through the MAPCP demonstration, CMS is participating as a payer to existing state multi-payer reform initiatives that expand the patient centered medical home model. The demonstration program will pay a monthly care management fee (PMPM) for beneficiaries receiving primary care from medical homes. This fee is intended to cover care coordination, improved patient access, patient education and other services to support chronically ill patients. The goal of this demonstration is to improve the quality and coordination of health care services. Eight states were chosen to participate in this demonstration and each state project is unique and conducted and coordinated by the individual states with Medicare paying its share.

One of the states chosen to participate was Pennsylvania and its Chronic Care Initiative (CCI).<sup>34</sup> The CCI was rolled out across the state in seven regions with regional differences in program and payment models across two phases. Under Phase I, different payment models for rewarding patient-centered medical homes were tested including lump sum payments to practices to cover start-up infrastructure costs, PMP payments, and shared savings. Practices that achieved higher levels of NCQA recognition received higher payments than lower level

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<sup>33</sup> Steiner BD, et al. Community Care of North Carolina: Improving Care Through Community Health Networks. *Annals of Family Medicine*. July 1, 2008; 6(4); 361-367.

<sup>34</sup> National Academy for State Health Policy. *Medical Homes and Health Homes; Pennsylvania*. November 2012. Available at: <http://www.nashp.org/med-home-states/pennsylvania>.



## ***Alternative Payment Methodologies:*** A Review of Past, Current, and Future Mechanisms

practices. Under Phase II, all practices receive two PMPM payments for “Physician Coordinated Care Oversight Services” and “Coordinated Care Fees”. Payments are age adjusted and meant to cover the expense of care coordinator positions found in the medical home model. Providers are also eligible for shared savings payments based on care cost and quality metrics. Over time, the PMPM payments will decrease but the percentage of shared savings the practices are eligible for will increase. Detailed results will be coming in 2013 but early results show improvement on clinical measures such as diabetes control and asthma with reductions in emergency room visits and overall costs.<sup>35</sup>

### **Conclusion**

In order to achieve the full transition to the “Triple Aim” goals of improved care, improved health, and lower costs, there must be a shift to the primary care home model. If the primary care delivery system can be transformed into medical homes without excluding certain payers and containing homes of all sizes and in all locations, there exists the potential for service delivery transformation that can result in significant cost savings. However, this can pose a significant challenge for many, especially the small, independent practices that lack the support of a health system. With sufficient investments and education around practice transformation a statewide change can occur and healthcare in the state can flourish and result in cost savings.

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<sup>35</sup> Torregrossa AS. Pennsylvania’s Efforts to Transform Primary Care. February 2010. Available at: [www.cthealthpolicy.org/webinars/20100223\\_atorregrossa\\_webinar.pdf](http://www.cthealthpolicy.org/webinars/20100223_atorregrossa_webinar.pdf).

## **Understanding Payment Logistics**

In order to determine which payment methodology is most effective and cost-efficient, one must have a definitive understanding of the total cost of care as well as the risks that are associated with each different payment model. Payers will need to determine the total cost of care in a way that includes factors regarding the number of care episodes and treatment a patient may receive for various conditions. The total cost of care determination can then be used to decide which payment methodology would be the most effective at delivery quality results at a reduced cost. Each methodology then comes with an associated level of risk that will also need to be considered. The following sections describe total cost of care and financial risk as they are two major logistical components of payment reform.

### **Total Cost of Care**

Each alternative payment methodology has different effects on factors such as cost of care, differences in patient populations, and severity of illness that must be taken into account when constructing a payment system. According to Harold Miller, Executive Director of the Center for Healthcare Quality and Payment Reform, total per capita health care costs are driven by:

- The prevalence of health conditions in the population;
- The number of “episodes of care” they require per condition;
- The number and types of health care services a person receives in each episode;
- The number and types of processes, devices and drugs involved in each service; and
- The cost of each individual process, device, and drug.<sup>36</sup>

If any one of the above variables increases, the overall cost of care also increases. The framework of which payment system is designed depends on whether costs are paid for separately or whether one fee covers multiple services in a bundle as described in the previous section. Miller uses the formula below as an illustration of how these variables work with one another.<sup>37</sup>

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<sup>36</sup> Miller HD. From Volume to Value: Better Ways to Pay for Health Care. *Health Affairs* 28(5) 2009; 1418-1428.

<sup>37</sup> Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund. September 2007.

## **Alternative Payment Methodologies:** A Review of Past, Current, and Future Mechanisms

$$\frac{\text{Cost}}{\text{Patient}} = \frac{\text{Cost}}{\text{Process}} \times \frac{\# \text{ of processes}}{\text{Service}} \times \frac{\# \text{ of services}}{\text{Episode of care}} \times \frac{\# \text{ of episodes of care}}{\text{Condition}} \times \frac{\# \text{ of conditions}}{\text{Patient}}$$

It is important to note that not all costs are necessarily incurred during the same timeframe and not all of them are direct costs. One typically considers the cost of care to be those charges that are incurred at the time of service. This portion of the overall cost of care is referred to as short-run direct costs. However, one must also consider short-run indirect costs, the cost of lost productivity during recovery; long-run direct costs, future provider expenditures that are attributed to current care (or lack thereof); and long-run indirect costs, the cost of lost productivity in the future as a result of current care (or lack thereof). The total cost can be tabulated as the sum of each of these.<sup>38</sup>

$$\text{Overall Cost of Care} = \text{Shortrun direct costs} + \text{Shortrun indirect costs} + \text{Present value of Longrun direct costs} + \text{Present value of Long run indirect costs}$$

For example, a provider overlooks giving a patient a routine measles vaccine during an exam. As a result, the patient contracts measles at some point in the future. The total cost of care that can be associated with the initial exam visit is the cost for services provided at the visit plus the cost of all services relating to the measles treatment plus the cost of lost productivity (i.e. time off of work, etc.) during the patient's recovery from measles. Under a FFS system, total expenditures will be greater for the payer since he is responsible for reimbursing the long-run direct costs. In this instance, the long-run direct cost is the cost of service for measles treatment. However, in a system that uses capitation for reimbursement, the provider assumes responsibility for the total care of the patient, which would include treatment for measles. This care would be provided without any additional reimbursement by the payer. The value of considering long-run costs becomes increasingly apparent when tabulating the cost of care for preventive services. The long-run costs associated with a lack of available preventive services outweigh the short-run direct costs or providing many of those services.

### **Determining the Financial Risk**

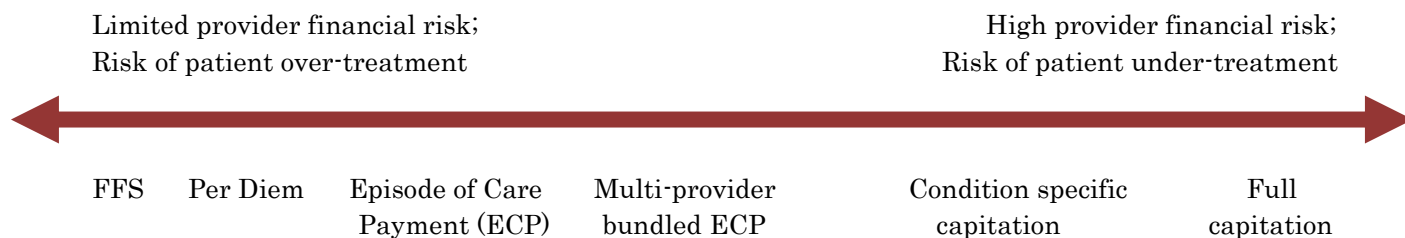
In addition to understanding the cost factors, it is imperative to consider the financial risk that is assumed by both payers and providers when determining a method of reimbursement. The level of financial risk for the total cost of care that is assumed by the provider can serve as the basis for encouraging more efficient

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<sup>38</sup> Ibid.

**Alternative Payment Methodologies:** A Review of Past, Current, and Future Mechanisms

provisions of care and each type of provider reimbursement method carries its own set of risk that are assumed either by the payer, the provider, or both. As a payment system moves down the continuum of healthcare payment methods from FFS toward full capitation, the risk shifts from payer to provider.<sup>39</sup>



FFS systems tend to provide financial incentives for providers to over-treat patients. The payer must assume the full risk of care in that the payments are made for as many services as the provider is willing to render. Episode-of-care payments put slightly more risk on the provider since it is unknown at the beginning of the “episode” exactly what services may be needed. Capitation creates incentives for providers to prevent illness in the patient and to treat any illness in an efficient manner. However, this also puts providers at risk if they treat populations that are sicker than average may cause them to under-treat their patients unless the under-treatment will lead to care for which the provider is at risk (e.g., a provider not administering the measles vaccine).

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<sup>39</sup> Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. Op cit.

## **Implementing a New Payment Methodology**

Even after determining the total cost of care and understanding what level of financial risk providers can reasonably be expected to bear, implementing Alternative Payment Methodologies can be challenging and may involve many significant barriers. Because of this, progress in changing payment systems that have been in place for decades has been slow. A transitional approach may be needed to overcome these barriers and work toward efficient, high-quality care. Harold Miller, Executive Director of the Center for Healthcare Quality and Payment Reform, identified ten major barriers to healthcare payment reform and possible solutions. They are featured on the next page.

## Alternative Payment Methodologies: A Review of Past, Current, and Future Mechanisms

Barriers	Possible Solutions
1. Continued use of fee-for-service payment in payment reforms	<ul style="list-style-type: none"> <li>Use episode-of-care payment for acute conditions and global payments for all patients to eliminate undesirable incentives under fee-for-service and to give providers the flexibility and accountability to reduce costs and improve quality.</li> </ul>
2. Expecting providers to be accountable for costs they cannot control	<ul style="list-style-type: none"> <li>Use risk adjustment and risk limits to keep insurance risk with payers but transfer performance risk to providers</li> <li>Use risk exclusions to give providers accountability only for the types of costs they are able to control</li> <li>Make provisions for contract adjustments to deal with unforeseen events</li> </ul>
3. Physician compensation based on volume, not value	<ul style="list-style-type: none"> <li>Change physician compensation systems to match incentives under payment reform</li> <li>Modify federal and state fraud and abuse laws to permit gain-sharing between hospitals and physicians</li> </ul>
4. Lack of data for setting payment amounts	<ul style="list-style-type: none"> <li>Give providers access to timely analyses of both utilization and costs through community multi-payer claims databases</li> </ul>
5. Lack of patient engagement	<ul style="list-style-type: none"> <li>Ask patients to designate their primary care physicians rather than using statistical attribution rules based on fee-for-service claims to assign them retrospectively</li> <li>Use value-based benefit designs to enable and encourage patients to improve health, adhere to treatment plans, and choose high-value providers and services</li> </ul>
6. Inadequate measures of the quality of care	<ul style="list-style-type: none"> <li>Develop quality measures for all of the conditions and procedures that drive significant amounts of cost</li> <li>Use outcome measures instead of process measures to give providers flexibility to redesign care and support effective patient choice</li> <li>Collect patient-reported information on outcomes</li> </ul>
7. Lack of alignment among payers	<ul style="list-style-type: none"> <li>Ask physicians and other providers to define lower-cost, higher-quality ways to deliver care and the payment changes needed to support them</li> <li>Encourage employers to support regional payment reforms and to choose health plans which will implement them in a coordinated way</li> <li>Offer Medicare payment reforms to a broad range of providers on an ongoing basis</li> <li>Use state government and/or collaborative to facilitate agreement among payers</li> </ul>
8. Negative impacts on hospitals	<ul style="list-style-type: none"> <li>Reduce fixed costs and improve efficiencies in hospitals</li> <li>Change payment levels to hospitals to reflect higher costs per admission that may accompany lower admission rates</li> <li>Increase transparency about hospital costs to ensure that prices for hospital care are adequate, but not excessive</li> </ul>
9. Policies favoring large provider organizations	<ul style="list-style-type: none"> <li>Remove anti-trust barriers to small physician practices joining together to manage new payment models</li> <li>Combat anti-competitive practices by large providers</li> <li>Avoid unnecessary standards for structure and processes in payment systems and accreditation systems that increase costs and favor large organizations</li> </ul>
10. Lack of neutral convening and coordination mechanisms	<ul style="list-style-type: none"> <li>Support the creation and operation of multi-stakeholder Regional Health Improvement Collaboratives or other forums to facilitate discussions</li> </ul>

Source: Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Center for Healthcare Quality and Payment Reform. December 2012.

## **Alternative Payment Methodologies: A Review of Past, Current, and Future Mechanisms**

It is important to note that large scale changes are necessary in order to implement payment reform. There are certain areas that will require particular attention when implementing payment reform: ensuring access to timely data, determining the appropriate financial risk, aligning incentives with adequate quality measures, solving contractual issues, and creating collaborative in which to share best practices and foster collaboration. Further descriptions are given below.

### **Ensuring Access to Timely Data**

In order to properly transition from volume-based care to value-based care, physicians, payers, hospitals, patients and other stakeholders must have the ability to share all relevant information, in an accessible manner that is integrated into the ordinary workflow, at the point of care. Many health care professionals and institutions lack the information and infrastructure they need to assess whether the services they provide and bill for care that actually improves the health of their patients. To this end, having access to the right data is critical in the assessment of how alternative payment methodologies will affect cost and utilization in various settings.

However, even if providers have access to claims data, most would not have the analytic capacity to assemble and analyze large claims databases, particularly if the data come from multiple payers.<sup>40</sup> Data and analytics require timely and actionable data to fuel the range of models needed to transform payment reform. A larger network of healthcare providers would require a large analytic arm in order to provide evidence-based research on payment reform efficacy.

In Oregon, the Office of Health Analytics provides unique and valuable resources that can aid enhanced information sharing: all key health-related data sets containing claims/encounters; long-term services and support, and other services and supports outside of CCOs; surveys including CAHPS and BRFSS; and integrated data sets such as the All-Payer All-Claims (APAC) database, and the Client Process Monitoring System (CPMS), which contains clinical data for mental health/chemical dependency treatment services. The state government's investment in data and analytic tools will allow for actionable data to enable testing of payment models.

According to the American Medical Association's Innovators Committee, value-based health care requires significant improvements in the development of health information technology that can be divided into three stages:

- The **First Stage** includes mature technology, such as practice management systems, designed to improve scheduling, billing and coding accuracy, and revenue cycle management in an FFS environment.
- The **Second Stage** includes the development of Electronic Health Records (EHRs) and other data sharing systems designed to foster health information exchange (HIE) and clinical support.
- The **Third Stage** includes population-based health management systems designed to integrate the practice management, patient stratification, clinical risk quantification, attribution methodologies and the HIE capabilities of the first two stages.<sup>41</sup>

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<sup>40</sup> Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Op cit.

<sup>41</sup> American Medical Association Innovators Committee. Physician Payment Reform: Early Innovators Share What They Have Learned. American Medical Association. July 2012.

## **Alternative Payment Methodologies: A Review of Past, Current, and Future Mechanisms**

The health information technology stages identified by the AMA should not be confused with the stages of meaningful use of Electronic Health Records (EHRs), as defined in the Centers for Medicare and Medicaid Services (CMS) regulations for the Medicare and Medicaid HER Incentive Programs.<sup>42</sup> Participants in those programs must use certified HER technology; that is, EHRs that meet technical standards set by the Office of the National Coordinator for Health IT (ONC). Together, the CMS and ONC regulations promote use of interoperable systems that support capturing and securely exchanging health information. Such technology is a building block for better communication of useable information, clinical decision support, improved care coordination and avoidance of duplicative services, and more advanced analytics. While various HIT efforts are an improvement in the infrastructure, there will also need to be efforts made to improve payment systems or align them with value-based care. This means a system will need to be configured to support making payments for episodes of care in addition to traditional FFS payment capabilities, which could be done by integrating claims and clinical data through a system such as a health information exchange (HIE).

### **Determining the Appropriate Financial Risk**

Movement to an alternative payment methodology will involve managing risk while ensuring quality, accountability, and equity across the provider network. Payment methodologies should adjust provider financial risk to account for inherently expensive patients or adjust for costs that the provider cannot control. The following methods to limit risk are being used:

- Condition/Severity Adjustments that would pay a provider different amounts depending on the type and severity of the member's health condition;
- Outlier Payments and Adjustments that would pay a provider more when the cost of caring for the member exceeds a defined threshold, or would reflect appropriate levels of accountability and outcomes measurement related to the total cost or quality of care when certain conditions are met;
- Risk Corridors that limit the extent to which the cost of actual service delivery for a group of patients far exceeds the payment typically allocated for defined conditions, services, and procedures; and
- Exclusions and Risk-Sharing arrangements that exclude the costs of services provided by certain outside providers from payments or having two providers accept accountability (and the associated payment) for different portions of the total costs of caring for a group of patients.

In addition to risk adjustments, payers need to consider being able to track a patient's health status over time. If a patient remains healthy as a result of care from a particular provider, the patient's health status today will result in a lower payment under a risk-adjusted system than if the patient remained unhealthy. Improved risk adjustment systems that capture such changes over time will be needed, particularly if more providers and payers sign multi-year contracts to manage healthcare cost and quality.<sup>43</sup>

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<sup>42</sup> More information about the Medicaid HER Incentive Programs is available at <http://www.cms.gov/Regulations-And-Guidance/Legislation/EHRIncentivePrograms/Index.html>.

<sup>43</sup> Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Op cit.



## **Aligning Incentives with Adequate Quality Measures**

The ability to analyze and share data must be paired with quality measures, either performance or outcomes based, to maximize providers' abilities to improve their performance and value to the system. It is imperative that when developing measures for a new payment methodology, the measures with which performance is assessed and payments are based, should be mutually agreed upon and appropriately aligned across providers and settings. It will also be important to ensure that providers and hospitals are capturing data and applying measures that are consistently and efficiently reported and that support improved quality of care and improved health outcomes at the practice level. There are a number of entities whose work in the area of physician quality performance is generally accepted, including but not limited to the following:

- **The Physician Consortium for Performance Improvement (PCPI)**- A physician led initiative that includes methodological experts, clinical experts representing more than 50 national medical specialty societies, the Agency of Health Research and Quality (AHRQ), and the CMS. The PCPI's measures can be accessed through the American Medical Association's website at [www.ama-assn.org](http://www.ama-assn.org).
- **The National Quality Forum (NQF)**- A measure endorsement entity that periodically reviews and endorses quality measures developed by the PCPI and similar entities. The list of NQF endorsed measures can be accessed by visiting [www.qualityforum.org](http://www.qualityforum.org)
- **National Medical Specialty Societies**- These societies have developed their own quality measures for their medical specialties that can be accessed through their respective websites or by contacting them directly.<sup>44</sup>

On the other hand, measures that are outcomes-based provide an integrative assessment of quality reflective of multiple care processes across the continuum of care. There a variety of types of outcome measures such as health or functional status, clinical measurements, adverse outcomes and complications, morbidity and mortality, patient-reported outcomes, patient experience with care, and others.<sup>45</sup> To foster higher quality and more efficient delivery of health care services in Medicaid, CCOs are awarded funds based on their performance on 17 initial outcomes and quality measures established through a statutorily mandated Metrics and Scoring committee with a public process and negotiations with CMS. CCOs are also encouraged to use alternative payment methodologies that will shift payments based on volume of service to payments based on outcomes measures.

Aligning the right incentives to the appropriate outcomes is also a critical piece of the reimbursement puzzle and requires careful planning. Incentives should be considered that will help providers to perform the tasks necessary to be successful. A Robert Wood Johnson Foundation

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<sup>44</sup> American Medical Association. Evaluating and negotiating Emerging Payment Options. 2012. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/claims-revenue-cycle-managed-care-contracting/evaluating-payment-options.page?>

<sup>45</sup> The Physician Consortium for Performance Improvement Convened by the American Medical Association. Measures Development, Methodology, and Oversight Advisory Committee: Recommendations to PCPI Work Groups on Outcomes Measures. August 2011. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvementpage?>

## **Alternative Payment Methodologies: A Review of Past, Current, and Future Mechanisms**

study<sup>46</sup> that tested the use of financial incentives to improve the quality of health care found that while financial incentives motivate change, they need to be large enough to make a difference. However, there is no real indicator of how much of an incentive is enough. Although, one of the projects included in the study conducted by the RWJF, led by General Electric, suggested that incentives should be a minimum of \$5,000 per physician per year in order to affect quality improvement. Others suggested incentives need to account for at least 10% of a physician's annual income. The study also found that merely providing support for additional staffing to make a physician's job easier or supporting infrastructure to supplement technology can motivate physicians to achieve quality targets.

### **Solving Contractual Issues**

Transitioning to an alternative payment methodology can take time to implement and improvements in cost and care may not be seen immediately. To account for this, long-term contracts should be developed. Multi-year contracts provide a better opportunity for providers to make changes in care delivery that take time to implement and to reap returns on investments in preventive care and infrastructure, and they give payers greater ability to control the trend in health-care costs.<sup>47</sup> For example, the Alternative Quality Contract developed by Massachusetts Blue Cross Blue Shield is a five-year contract that was designed to slow the growth in spending rather than achieve immediate savings. However, contractual mechanisms must be considered to allow adjustments based on unforeseen changes in the marketplace, such as major shifts in healthcare policy.

Hospitals and providers also need to be made aware of the specific payment arrangement and what measures will be used in which to calculate payment amounts. In addition to measurement transparency, contracts will need to include other specifics to mitigate concerns regarding "gainsharing". Gainsharing refers to hospitals giving providers a share of cost reductions for patient care attributable to a physician's efforts that in some cases have limited services to Medicare or Medicaid beneficiaries. Consequently, gainsharing programs that are designed to reward physicians for reducing unnecessary services or unnecessary elements of services may be determined to violate the Civil Monetary Penalty statute and may in some circumstances implicate the federal Anti-Kickback statute.<sup>48</sup> However, the Federal Trade Commission, in collaboration with Medicare, has established a new safety zone in federal anti-trust enforcement as a means to encourage participation in the Medicare Shared Savings Program, and the Office of Inspector General has issued a series of waivers from certain fraud and abuse statutes.<sup>49</sup>

### **Creating Collaboratives**

Bringing health insurers, patients, employers, and physicians to the table would highlight opportunities to improve coordination and continuity of care; new paradigms for quality

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<sup>46</sup> Brown MH. Reviewing Results: Aligning Incentives with High-Quality Health Care. Robert Wood Johnson foundation. October 15, 2009. Available at: <http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/10/rewarding-results.html>.

<sup>47</sup> Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Op cit.

<sup>48</sup> See the July 1999 DHHS-OIG Special Advisory Bulletin, Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce of Limit Services to Beneficiaries. Available at: <http://oig.hhs.gov/fraud/docs/alertsandbulletins/gainsh.htm>.

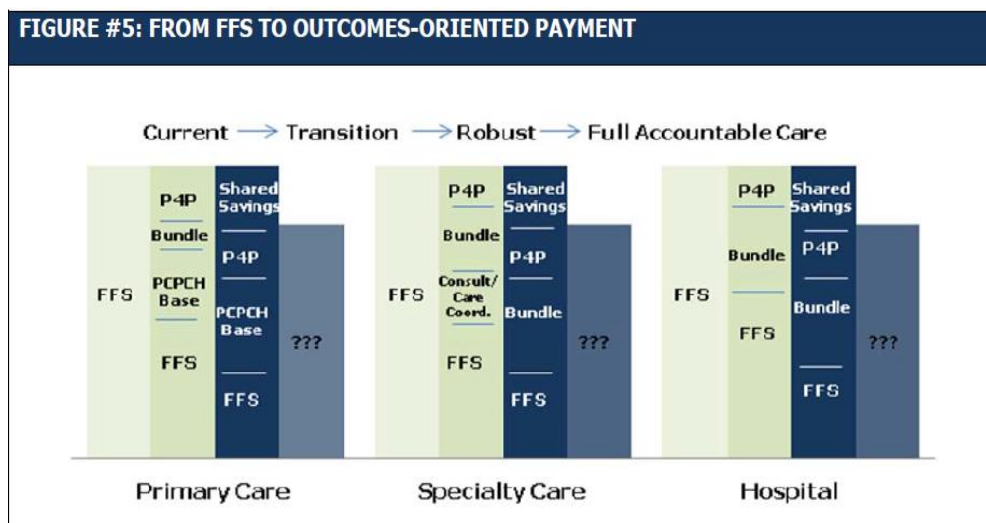
<sup>49</sup> American Medical Association Innovators Committee, op cit.

**Alternative Payment Methodologies:** A Review of Past, Current, and Future Mechanisms

improvement that integrate assessment at the individual physician level and institution level could emerge.<sup>50</sup> Nationally, a growing number of communities are recognizing that Regional Health Improvement Collaboratives (RHIC) are an ideal mechanism for developing local or regional collaborative, such as multi-stakeholder solutions, to facilitate discussion regarding their healthcare cost and quality problems. These collaborative provide a neutral, trusted mechanism through which the community can plan, facilitate, and coordinate the many different activities required for successful transformation of its healthcare system. This includes payment and delivery system reform. Representation on a RHIC generally includes healthcare providers, payers, purchasers of health care, and consumers that work together to help the stakeholders in their community identify opportunities for improving healthcare quality and value, and facilitate planning and implementation of strategies for addressing those opportunities.

**Transitional Approach**

Payment reform is not a “one size fits all” approach. Some payers and providers may be prepared to implement APMs immediately while others may need a flexible approach in order to transition to a truly value-based payment system. Payers and Providers could initially shift from FFS to shared savings and then work towards episode payments and more complicated risk arrangements. In March 2010, the Oregon Health Policy Board established the Health Incentives and Outcomes Committee to develop recommendations on transparent payment methodologies that provide incentives for cost-effective patient-centered care and that reduce variations in cost and quality of care. After thorough research and discussion, the committee recommended the use of P4P, bundled payment, and shared savings models with a vision of transformation from FFS to the more outcomes-oriented payment models. This vision is illustrated in the figure below for three major categories of providers: primary care practices, specialty practices, and hospitals.<sup>51</sup>



<sup>50</sup> Wharam JF, Paasche-Orlow MK, Farber NJ, et al. High Quality Care and Ethical Pay-for-Performance: A Society of General Internal Medicine Policy analysis. *Journal of General Internal Medicine*. July 2009; 24(7): 854-859.

<sup>51</sup> Oregon Health Policy Board, Office for Oregon Health Policy and Research. Health Incentives and Outcomes Committee Report and Recommendations. November 2010. Available at:

<http://www.oregon.gov/oha/OHPR/HPB/pages/healthincentives/healthincentivesandoutcomescommittee.aspx>.

## **Conclusion**

Health care expenditures are increasing both nationwide, as well as in the state of Maryland. Healthcare payers must make efforts to move away from the traditional fee-for-service payment system that rewards volume rather than value. Re-aligning the priorities of Oregon's healthcare system using alternative payment methodologies will allow for provider incentives to include quality and efficiency in health care services and will result in a higher level of illness prevention, more accurate diagnoses/prognoses of conditions, more appropriate care reflecting patient preference and engagement, avoidance of adverse events, and improvements in follow-up to care. All of these results will ultimately end up contributing to greater quality of care and lower health care costs due to a healthier population and reductions in hospital admissions.

Promising initiatives have paved the way for others in determining how best to implement an alternative payment methodology. Early examples such as Geisinger's ProvenCare has taught us that surgeons can not only work to improve care through evidence-based treatments, but they can use shared decision-making processes with patients and initiate explicit post discharge instructions that can result in a 10% decrease in hospital readmissions. Commercial efforts in bundled payments, such as the CalPERS effort, have shown us that bargaining power can result in savings without negatively affecting outcomes. The BCBS of Illinois shared savings program and the Bridges to Excellence P4P program under the Colorado Business Group on Health have long proven that incentives for providers to produce results in specific quality indicators can improve outcomes and also reduce hospital admissions. Furthermore, there has been particularly strong evidence of PCMH payment models enhancing quality of care and reducing hospital admissions by enabling practices to invest in needed infrastructure and rewarding their providers for quality rather than quantity.

As these payments reform initiatives and other national examples have shown promising results, more work will need to be done at the community level to prepare for comprehensive payment reform in Oregon. Areas that will require particular attention include ensuring access to timely data, determining the appropriate financial risk, aligning incentives with adequate quality measures, solving contracting issues and creating collaborative in which to share best practices and foster collaboration. While a single method may be able to produce some improvement, multiple payment methods, coordinated and aligned between multiple payers to produce appropriate incentives, can work together to yield cost containment and improved quality and outcomes for health care services. The OHA believes that for most providers, the path from fee-for-service payment to comprehensive payment reform will transverse some intermediate ground wherein providers are paid in a mix of ways as they transition to greater accountability for outcomes, quality, and efficiency.

2014



**MACHC**  
Mid-Atlantic Association of  
Community Health Centers

The Mid-Atlantic Association of Community Health Centers (MACHC) is a 31-year old non-profit membership organization, whose members consist of community, migrant and homeless health centers, local non-profit and community-owned healthcare programs. MACHC is the federally designated Primary Care Association for Delaware and Maryland Health Centers. Our members provide health care services to the medically underserved and uninsured in Maryland and Delaware. MACHC is built on helping our members in the delivery of accessible, affordable, cost effective, and quality primary health care to those in need.

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